DOCUMENT RESUME

ED 163 312 CG 012 996

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TITLE Structure, Function, and Training the Rehabilitation Team.
PUB DATE 22 Mar 78
NOTE 13p.; For related document see CG 012 995

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS *Cooperation; *Delivery Systems; Group Unity; *Interdisciplinary Approach; Interprofessional Relationship; Mental Health Clinics; Program Descriptions; *Rehabilitation; Team Training; *Teamwork; Therapeutic Environment

ABSTRACT

The traditional team concept in rehabilitation is a differentiated team in which each member performs a different function. In practice, such teams are rarely cooperative and their additive services are disjointed. Presented is the philosophic rationale for the revitalization of a large rehabilitation center serving mental patients. Reorganization of the service component was built around cooperative team function. Team composition, function, and training provided are described. The pivotal concept is impact on a client through cooperative effort. Unlike most expert teams, the client also holds team membership, and often serves to keep the team on track. Team composition is defined operationally, and the nucleus of team training is briefly described. Data were collected on the effectiveness of the project and are reported briefly. (Author)

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Structure, Function, and Training the Rehabilitation Team

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Background

As all teamsters know, it takes many horses to pull a heavy load. Such is the case with serving the severely disabled in vocational rehabilitation. Teamsters also know, however, that one's horses must pull in the same direction or they end up pulling against each other. This lesson has not been well learned by rehabilitation teams. The team approach to service delivery in rehabilitation is not a new concept. Since the late forties and early fifties a rehabilitation team has been envisioned as one method of organizing the delivery of multiple services to the disabled person.

The team concept has matured in one form in the area of physical medicine, and might be attributed to such grandfathers in the field as Howard Rusk and Henry Kessler. The early rehabilitation team consisted of a physiatrist, physical therapist, occupational therapist, psychologist, social worker, and a vocational counselor. This august team of professionals was acknowledged as possessing among their membership the highest levels of professional acquisition and skill and the critical missing ingredient prior to this time was the assembly of such a team under one roof. There can be little doubt but that the teams so assembled were instrumental in advancing the field of physical medicine and rehabilitation.

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Such a team should be known as a differentiated team or a team based upon specialization in which the role of each of the participants is clearly defined and those with different occupational titles serve different functions with reference to the clients. This team structure is represented schematically in Figure 1.

In practice the differentiated team produced a literature characterized by a preoccupation with role definition and differentiation. This amounts to specifying which functions belong to which professions. Once this is accomplished, the stage is set for the development of territorial jealousy as well as the opportunity for clients to get lost between the various role definitions. Under this form of team structure, the physiatrist is usually the team captain and the majority of the team members are paramedical professionals under his supervision. Team dissention more often than not centers around the relationships between those in the behavioral sciences, the social service personnel, whose territory is least well defined. Psychology, social work, and rehabilitation counseling are in each other's territory a great deal of the time.

Of more recent vintage is the development of teams to serve mental patients. The team in this context has also developed a literature under a variety of titles described as milieu therapy, the therapeutic community, or the therapeutic environment. In the case of these teams, there is no legitimate scientific base available for its practice so the focus of all team members is something like community and personal adjustment.

Under this circumstance, clean role differentiation is clearly impossible and all team members, unlike the differentiated team above, find themselves standing on the same piece of turf. In addressing this dilemma, Jones (1968) states:

> No amount of individual skill in one's own particular profession can circumvent the need for group skills with a view to understanding the dynamics of individuals when they interact, the problems of decision-making, social learning, leadership, and other topics. Multiple leadership in a multidisciplinary setting is an essential goal which coordinated services must set for themselves if they are going to be optimally useful. This implies not only suitable training in one's own profession and a far greater degree of interdisciplinary training than at present exists, but continued on-the-job training by the utilization of living-learning situations. Multiple leadership is at present a most crucial area and it is here that knowledge and competent training are most lacking.

In addressing the issue of interdisciplinary or inter-professional cooperation, Jones continues:

> Concerning a spirit of cooperation and the integration of service delivery through such teams each has his own particular area of competence and how far his area can achieve its full usefulness will depend upon the capacity of the leader to utilize the skills of the allied services and bring about one unified community service with multiple leadership. At the moment such integration of services is left largely to chance and the good will of the personnel concerned . . . . Everywhere one sees signs of the unwillingness on the part of any one discipline to give up any of its authority and even within a single discipline, like social work, despite active attempts at professional integration, the various sub-groups in practice showed little enthusiasm to relinquish any of their existing power.

It is sufficient for our purposes and our conclusion that the differentiated team is, in fact, not a team. It may conform to some notion of non-overlap or non-duplication of service and the attendant preoccupation of such notion with precise role definition. Avoiding duplication or overlap is an idealistic

concept, but in practice often functions so as to prevent legitimate cooperative effort. For this reason our approach to team structure, function, and training is developed from the notion of client impact. In the final analysis, the only measure of team effectiveness is its influence on those it serves.

It is from this background that a pilot project was instituted in a large rehabiltitation center located on the grounds of a state hospital complex. In broad perspective our interest was to develop a team structure which would encourage cooperative function and establish the team as the service component of this facility.

Our review of the literature supports Jones' conclusion that little has been done to make institutionally-based teams of people responsible to deliver services to clients in such a way that the client, rather than the professional, is served. It is also the author's conviction that interdisciplinary teams could function on a cooperative basis, provided full cognizance was taken of the pitfalls identified within the literature, and a process of systematic team development be implemented with its focus being direct client service.

Team Structure

The most succinct premise consistent with our thinking is the statement by Jones (1969) that: "The face-to-face work group is the unit of diagnosis and change." The evidence to support the reality of this statement is overwhelming. Yet in practice the mental health team captain often has little regular face-to-face

contact with clients. Those who have daily impact on clients are often not even team members. This form of team structure is inane and team function is non-existent. The authors' efforts were to restructure the mental health rehabilitation team and conduct team training in such a way as to draw upon the strength of those in the best position to make a difference. With the help of a large rehabilitation center specializing in services to the mental patient, a new type of team structure was formed and trained from scratch.

Our operational definition of a team includes those staff members who have regular face-to-face client contact. As the facility involved was a large comprehensive residential program, an initial pilot team was formed in such a way that equivalent teams could be developed later if it was warranted. The initial team consisted of the following members:

rehabilitation counselor (1)
evaluator (1)
residence hall attendants (4)
social worker (1)
instructor (1)
work adjustment person (1)

This prototype team was charged with responsibility to serve all clients within a given residential area of the facility. This included recruiting, intake, evaluation, counseling, program development, work adjustment, training and to some extent placement and follow-up. The reaction and response to this novel

team structure were notable. Some of the subtle influences were insidious but many were readily and instantly apparent.

Focusing on the structural changes first, the counselors became the primary public relations agents for the facility. They were charged to develop and sell the program to the field staff in their geographic area. In rehabilitation the reality of this new structure is simple: no clients, no successful closures. This new responsibility requires the facility counselor to establish good communication and working relationships with the field counselor who ultimately supplies the clients. This structural change produced an increased sense of responsibility and accountability for the results obtained.

The evaluator is now responsible for the evaluation of team clients only. As he participates in all team meetings he is more knowledgeable about the team clients, is available to discuss his results and impressions with other team members, and is in a better position to obtain follow-up or feedback on client progress. One by-product of this new structure is that the evaluator is asked more frequently for specific in-depth or thorough evaluations of limited areas or keying in upon one's interpersonal behavior or conduct in evaluation.

The residence hall attendants are the most vocal advocates of team structure as they were not formerly considered a vital component in the program. In a residence facility the problems which arise and the potential for impact are not limited to normal working hours. In fact, the more exciting time periods in a facility are off hours. The attendants are in a key position

to help identify and deal with the problems which appear in such a program. Their cooperative assistance and their impact on clients make them an indispensable part of the team.

The instructors and work adjustment personnel are the team members who have official responsibility to work with team and non-team clients. Their participation in the team meetings, however, serves some useful purposes. They provide communication links with other instructors and work adjustment personnel and can often fulfill special needs for selected clients or function as troubleshooters with other staff members. They gain a far better view of the facility program and of their contribution to it. Participation in team meetings often provides them with suggestions about specific approaches to handling classroom or workshop problems.

Team Training

The above are some of the benefits through providing team "structure" of a given kind. This structuring has a beneficial effect on the function of individual team members. It does not assure teamwork or a cooperative support system necessary to develop the maximum impact on a client. For this reason team training was developed to establish the team as the service delivery unit for the facility and to initiate an open system of communication within the team.

A few basic principles were to be followed in training. The first was the conviction that all training should be held in the natural work setting of the team and should be conducted as a group. As impact is important, cooperative effort (rather than

differentiated individual effort) was the focus of training. Following some preliminary warm-up activities, training was developed around staffing conferences of team-selected problem clients.

Perception vs Diagnosis

As the face-to-face work group is the unit of diagnosis and change, the focus of training becomes the team members' perceptions of a client based upon their personal experience. This accumulation of perceptions is followed by the careful introduction of the client into the proceedings. His perceptions of his assets, problems, and program needs are solicited. This becomes the nucleus for further team deliberation and responsive program development. This is a particularly simple nucleus and by some standards is unscientific. The advantage of dealing with perceptions is that people achieve amazing agreement on their perceptions based on experience. Disagreement usually follows some theoretical or pseudoscientific notions about how such things develop, what to call it, and who is responsible to do what. As most of this does not normally follow the perceptions of people in the world, most of the disagreements never occur. The representation of this team is shown schematically in Figure 2. While the special contribution of each discipline is still apparent such discplines are held together by an area of common task responsibility. The differentiated team has no such function. A fully functioning team develops a particularly large area of common responsibility and as the result has little time for territorial jealousy or turf guarding. It remains for each team to determine the ways in which their cooperative involvement is required. An

obvious area of cooperation (and one on which most team members agree) is that one team member should not be played off against another by a client. When a team functions as a unit such client strategy does not work for long.

Dead End Activity

Some fascinating side trips are inevitable when dealing with groups of people. After two or three days opportunity to observe or interact with a new client, a variety of consistent perceptions across a number of team members develop. In sharing these perceptions, however, the first curious phenomenon occurs. There appears to be a strong tendency among mental health teams to proceed beyond the point of agreement about the problems or perceptions and to engage in witch hunts seeking causes rather than solutions to the problems. It was also observed that in many ways a specific problem could be identified as being a "psychiatric problem" which then becomes the exclusive province of psychiatry. The balance of the team members could breathe a sight of relief for their salvation. It soon became apparent that such witch hunts were fascinating, but non-productive, that team efforts should be concentrated upon those commonly shared perceptions of problems on which the team agreed. This resulted almost naturally in a problem-centered approach to each patient and the diagnostic classifications and sub-classifications of patients common to such facilities were virtually ignored or left to psychiatry as it were.

Summary

While a great deal of data has been collected on the work in this facility it should be sufficient at this point to summarize the achievements of the facility involved to date. The complete reorganization of this facility was instituted following experience with the pilot team project. Some rather dramatic programmatic revisions were instituted simultaneously with this restructuring around the autonomous service delivery team. Prior to such reorganization the census of this facility had dropped to a critical level as the host environment, a large state mental hospital, had regionalized and was itself suffering census problems. With this reorganization it was decided that the facility would become a referral facility for the field counselor. A full census has subsequently been achieved and during the fourth full quarter of operation more rehabilitated closures may be attributed to this facility than at any time in its twelve year history. This rather amazing feat must be attributed in large measure to the distinctive team structure which is fully responsible for all services and a courageous staff of administrators and supervisors who were willing to risk the uncertainty of making some dramatic changes.

RBS-JRC/sgr
Washington, D.C.
3/22/78

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FIGURE 1

TEAM COMPOSITION

BASED UPON UNIQUE CONTRIBUTION

TEAM FUNCTION

BASED UPON ROLE DEFINITION

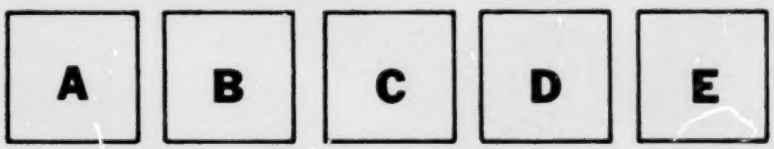

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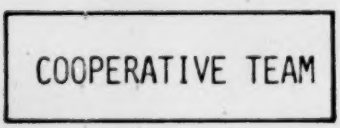
FIGURE 2



TEAM COMPOSITION

BASED UPON IMPACT

TEAM FUNCTION

BASED UPON COMMON TASK RESPONSIBILITY